State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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NICHOLAS A. TOUMPAS
COMMISSIONER

April 12, 2012

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, NH 03301

Dear Governor and the Honorable Executive Council:

I want to thank you for giving the NH Department of Health and Human Services the opportunity to respond to the questions that have been raised by you and many advocacy and provider organizations and individuals about the pending contracts for the Medicaid Care Management program.

Over 150 questions have been submitted to the Department since the March 28, 2012, Council meeting when the contracts were tabled. Many of the questions are duplicative or closely related. In order to present information regarding the questions in an integrated manner, they are categorized based on topic area. I am also including a separate document that explains risk-based managed care.

I look forward to continuing to work with you on this important new program for our Medicaid population.

Sincerely,

Nicholas A. Toumpas
Commissioner

Enclosures

In advance of the special meeting of the Governor and Executive Council on April 13, 2012, DHHS is providing the following information in response to the over 150 questions forwarded to us since the March 28, 2012 Governor and Executive Council meeting at which the three contracts for the Department's Care Management program were tabled. Many of the questions are duplicative or closely related. In order to present information regarding the questions in an integrated manner, they are categorized below based on topic area.

1. Contract Development and Approval

The Department began developing the Care Management Program in earnest in August and September 2011 when it held its stakeholder engagement process. The Request for Proposals was released in October with submittals due in mid-December. The proposals were evaluated and the bidders were selected in January. Based on an actuarial analysis the Department developed a capitated rate for the program which was submitted to and approved by the Fiscal Committee. Contract negotiations ensued until March, at such time the contracts were submitted to the Governor and Council for approval. Once approval is obtained, the contracts will be submitted to the federal Centers for Medicare and Medicaid Services (CMS) for approval. CMS will only consider the contracts after they are valid which, in NH, means after they have received all state approvals necessary.

The Department was deliberate in its approach to the RFP to promote unique and innovative approaches to the care management program. By posing questions rather than prescribing specific, narrow approaches, the Department was able to solicit information from the bidders about how they will use their knowledge and expertise to deliver quality health care services to the state's Medicaid population.

Under the new care management program DHHS will retain its responsibility to oversee the delivery of Medicaid services. The MCO contract has a number of safeguards in place to ensure that, as required by RSA 125 and in compliance with CMS regulations, there shall be no reduction in the quality of care or services provided to enrollees and the current quality of care provided shall be maintained or increased. Among the contract provisions is a requirement that prior to member enrollment Implementation Plans and Program Management Plans must be submitted by the MCOs to the Department for approval. In addition to these initial submissions, each MCO will need to submit and DHHS needs to approve the plans annually and any future changes. Based on the RFP proposals submitted by the MCO's, each MCO will have unique approaches to implementation and management of the program; however, they are all required to adhere to the requirements in the signed contract. Other provisions to protect the state include the requirement that the MCOs comply with state and federal laws, and provisions for liquidated damages and suspension of payments in the event of non-compliance.

DHHS approached the procurement process to provide the State of New Hampshire with the opportunity to work with managed care organizations that are in the best position to provide innovative approaches to the delivery of health care services, rather than an

approach that constricts innovation. By encouraging each MCO to develop its own unique approach, the program provides an additional level of choice for Medicaid members.

DHHS will create an MCO monitoring plan for each MCO. DHHS account managers will be assigned to each MCO to support daily oversight of all activities related to program implementation and operations.

2. Federal and State Laws

There is a large body of federal laws and regulations governing Medicaid and Medicaid Care Management. The Department has worked to make certain that all federal requirements are reflected in the contract and has followed the 'CMS Checklist for Managed Care Approval' to include the language of and reference to the federal regulations where appropriate. DHHS will post the completed check list when it is submitted to CMS. There are also New Hampshire laws and agency rules that apply to Medicaid, Managed Care, and the procurement process. DHHS and the NH Insurance Department have worked together to harmonize the many legal components relating to the licensing and operations of MCOs, and to coordinate the oversight responsibilities of each agency. (See NHID Bulletin Docket No. INS No. 12-015-AB, April 4, 2012.) References to these legal requirements are specifically indicated throughout the contract. In addition, Section 26 of the contract and paragraph 6 of the P-37 bind the MCOs and subcontractors to adhere to all applicable federal and state laws.

3. Transparency

DHHS has remained committed to transparency throughout the program development activities and has worked to keep the public informed while maintaining the integrity of the contracting process. The Department has posted over 40 documents concerning the program on its website. Prior to drafting and issuing the Request for Proposals, the Department conducted a stakeholder engagement process, holding six public forums, nine focus groups (including sessions with those populations whose services will be part of Step 2) and an online survey that garnered over 700 responses. The Department has briefed legislators, provider organizations, the Medical Care Advisory Committee and others throughout the development of the program.

As the program is implemented and operationalized, the Department will conduct outreach and education sessions and post public information. The Department is researching how other states have kept the public aware of the managed care organizations performance in the delivery of quality care.

4. Costs

The cost of the Managed Care program will be based on the number of Medicaid eligible members times the 'per member per month' (pmpm) rate of the contract. The pmpm rate does not reflect an individual cap on expenses. The only cap that exists is between the

state and the MCO. The pmpm rate, which is the same for all three MCOs, is based on an actuarial analysis provided by an independent Actuary retained by the State.

Each of the 22 rate cells, which separated the Medicaid population into 22 groups based upon age and other factors, were calculated based on historical NH Medicaid FFS cost and were then trended by the actuarial consultants to project future Medicaid costs if the state continued on the current FFS model. Each rate cell reflects an average cost over time, or pmpm, based upon the prior history of the members of that group. MCOs need sufficiently large membership to average out the high and low cost members. The prior history of members can be used to adjust the monthly payment, following the calculation provisions of contract. The contract allows MCOs with complex populations to be paid more than those with comparatively healthier population – this is called "risk-adjustment" and is a process DHHS will carry out on an annual basis with actuarial consultants. This risk adjustment ensures that MCOs will not discriminate against members based upon health status. Utilization and other assumptions were applied by the actuaries to develop the projected reduced costs of providing service to the state's Medicaid population through managed care. Included in this, is the risk adjustment process to support more complex healthcare issues. Through this actuarially sound process, required by CMS, DHHS developed the pmpm rate negotiated with the MCOs.

The key factors in determining the final rates, which were submitted to and approved by the Fiscal Committee of the General court, were prior years' actual cost experience in NH, projections of costs of maintaining FFS, assumptions of reductions in cost through implementation of care management, and contract negotiations, while at the same time ensuring actuarially soundness of the rates. Using this comprehensive approach to reach a pmpm rate, rather than focusing on specific MCO operational and financial components such as medical loss ratio and profit caps, provides a sound basis to implement the program.

Constant throughout is the foundational requirement that services will be maintained and improved for the vulnerable members of our population in the Medicaid program.

5. Improving Outcomes

A successful managed care program is based on improving outcomes rather than focused on rewarding activity. Studies show that more health care does not mean better health care. The goal of the state in implementing Medicaid managed care is to enhance the health of our members by providing quality services through improved and innovative methodologies. By developing contracts with three MCOs, the Department is providing the platform for the innovation each can bring to New Hampshire's program.

Through oversight and incentives DHHS must ensure that innovation brings better health outcomes for our members. The contract, along with federal and state laws and regulations, provides numerous requirements and protection mechanisms so that, as required by RSA 125, that there shall be no reduction in the quality of services provided

to enrollees. However, the goal is not to just maintain the quality of care but to increase it.

To drive toward this higher goal, DHHS will select each year four quality measures as part of an incentive program. Withholding a percent of the payments to each MCO pending their performance of the quality measures provides a financial incentive to meet the measures selected by DHHS.

The measures of the first year of the contracts are to increase adolescent well care visits, reduce readmissions to New Hampshire Hospital, improve the rate of maternal smoking cessation, and improve measures of members getting needed care.

6. Members' access to providers

In order to ensure the provision of services to members, safeguards are included in the managed care contract regarding both the geographic distance to providers and the timely access to service delivery.

Geographic access standards (Section 18.2.1) indicate in miles and times the maximum travel distances for various provider categories. Timely access to service delivery (Section 18.3) requires: availability of medically necessary services 24/7; minimum hours of operation of providers; and minimum waiting times for appointments for transitional care, preventive and routine care, urgent and emergency care, and behavioral health care.

In addition, there are provisions for members' access to Level I and Level II trauma care and specialty hospital services as well as out-of network providers. Members are also entitled to a second opinion, and can choose their health providers to the extent possible and appropriate.

Members may choose their own primary care provider in any of the MCO networks, or the MCO will assist the member in choosing a PCP appropriate to the member's prior history and current health care needs.

These access requirements are modeled on federal regulations which will be applied by CMS in its review of the contract, and NH Insurance Department rules.

It is a requirement that the MCOs develop robust provider networks. The Department is aware of the access challenges that exist in some parts of the state. However, the Department cannot overstep the state's authority regarding agreements between providers and the MCOs. DHHS will strictly oversee the levels and quality of care and will work with the MCOs so that members have access to needed services.

7. Enrollment

Individuals will continue to go through DHHS for Medicaid eligibility determination. They can do this through a district office, phone or NH Easy-- the same as today. Once eligibility is approved, the individual will receive information from the department about

the care management program that highlights the features of each MCO and how to go about making a choice among the three health plans. They will be assisted by workers who will be able to walk them through the differences among the companies, including the provider networks and if their PCP is in just one or all three plans. Once the selection is made, the department will send the information to the MCO which will then do its own outreach and education. The MCOs are required to maintain a robust member services program that will include a website, call center and other features. While some states have hired a company to serve as its enrollment broker, we are going to handle the function in house. We will augment our resources for the initial enrollment process to facilitate as smooth a transition as possible.

8. Behavioral Health & Long Term Care Services

The Department has included behavioral health services (Step 1) as well as the waivered services for the long term care population (Step 2) in the care management program to adhere to its central principle of taking a "whole person" approach. This was well vetted in the Legislature as the policy decisions were being made. The Department has set forth a number of requirements of the MCOs for the services, including that they establish and maintain access to critical services for Medicaid members.

The MCOs will negotiate contracts with individual providers and those contracts will lay out the expectations between the two parties. DHHS will remain responsible for ensuring that services are provided within the care management program.

The MCOs are required to coordinate care for its members, including primary care, specialty care and all other MCO covered services as well as Medicaid services provided through the fee for service program. The MCOs, its providers, and families and members will participate in the system of care model for children with serious emotional disturbance.

9. Provider payments standards

The current Medicaid FFS payment processing standards for clean claims are that 90% of must be paid within 30 days and 99% must be paid within 90 days. These FFS standards are in keeping with the minimum federal requirements of CMS for Medicaid payments. (42 CFR 447.45)

The contract with the MCOs, however, sets higher standards than the FFS and federal requirements. The contract raises the percentage of clean claims that must be paid in 30 days to 95%, rather than 90%. In addition, the contract requires 100%, rather than 99%, be paid in 60 days, rather than 90. (Note: NH RSAs related to Accident and Health Insurance, and commercial managed care products do not apply to Medicaid FFS or Medicaid Managed Care.) Furthermore, while the contract sets minimum payment standards, it does not preclude providers and MCOs from agreeing to even more favorable terms.

Similarly, the contract reflects basic requirements for provider incentive programs set by federal regulations. It does not preclude an MCO from submitting innovative

reimbursement methodologies to engage providers in health care delivery and payment reform activities such as global or bundled payments.

10. Provider protections

Federal law prohibits an MCO from discriminating against providers based on their scope of license or certification. Sections 19.2.19-.20 use the federal language which goes on to clarify that while MCOs may not discriminate for participation, reimbursement, or indemnification, they are not required to contract with providers beyond the number necessary to meet the needs of its members, precluded from using different reimbursement amounts for different specialties or practitioners, or from establishing measures to maintain quality of services and control costs. (See 42 CFR 438.12(a))

In addition, the contract contains provisions to ensure that provider enrollment, credentialing, model contracts, and other materials must meet federal regulatory requirements and be approved by the Department.

11. Oversight, accountability and protections

DHHS will be the primary oversight agency for the Medicaid Care Management program. However, the NH Insurance Department will oversee licensing and solvency requirements and other relevant insurance laws and regulations. (See NHID Bulletin Docket No. INS No. 12-015-AB, April 4, 2012.)

The contract requires DHHS approval of all critical policies, procedures and plans of each MCO regarding implementation and operations. Member enrollment, services, communications and quality programs are of primary concern.

DHHS, advised by the AG, strove to develop an RFP and contract that lay out the levels and quality of service to be provided to members while also maintaining an approach that allows for and encourages innovation from the MCOs on how they meet the program goals.

Once contracts are approved, DHHS can begin working with the MCOs to develop the Implementation and Program Management Plans that will be integrated into the contract as Exhibits K and L. These plans will include the steps, deliverables and timing of what must happen before the "go live" date and how each MCO and DHHS will manage the program. In keeping with Department goals, and the requirements of RSA 125, two readiness reviews will take place to ensure that there will be no reduction in the quality of care of services provided to enrollees and the current quality of care will be maintained or increased.

DHHS looks forward to a positive and productive partnership with the MCOs. However, built into the contract are numerous provisions for corrective processes, leading to sanctions, liquidated damages and other legal remedies should the Department need to exercise those protections.

12. Implementation Dependencies

There are several factors that will determine when the DHHS will be able to begin enrolling eligible individuals into the care management program. These include: CMS' approval of the contracts, capitated rates and State Plan Amendment; enrollment function; and the MCOs' readiness. While the Department is committed to implementing the program as soon as possible, it will not compromise Medicaid members' wellbeing to meet a particular deadline.